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When is "Cure" Not Enough?

Helping a Breast Cancer Patient to Overcome Fear and Regain a Positive Body Image

INTRODUCTION

The patient in this case is a breast cancer survivor. This article addresses the psychological, sexual, and social conflicts with which she struggles as a result of her mastectomy.

The article also illustrates the unfortunate situation that can occur when physicians rejoice over a lifesaving "cure" of an illness, while the patient despairs that life may no longer be worth living.

BREASTS AND THE CULTURE IN WHICH WE LIVE

We live in a mammocentric era where breasts are perceived as an important part of a woman's sexuality. Breasts are glamorized, idealized, and sensationalized. The media portray very powerful messages through advertisements where the sexual image of a woman is associated with skimpy clothes and cleavage, selling anything from cigarettes to a car. This puts undue pressure on women from the start as they perceive their breasts to be the main symbol of womanliness, sexual attractiveness, and nurturance.

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With such emphasis placed on her body image, a woman facing breast cancer surgery can feel anxious, vulnerable, angry, and depressed. Between 25 and 35 percent of American women diagnosed with breast cancer will develop anxiety and/or depression at some stage of their treatment, and for a substantial number this will be unremitting if they do not receive any help.[1] The loss of a breast through mastectomy has a more profound psychosocial impact than other types of cancer treatment.[2] There are sufficient data to suggest that amputation of the breast produces such a profoundly negative effect on feelings of feminity, self esteem, and body image that psychological and sexual dysfunction are an almost predictable outcome.[3,4]

CASE PRESENTATION

M. is a 58-year-old Hispanic married female secretary with a past psychiatric history of major depressive disorder who lives with her second husband of 30 years. She presented with complaints of consistently feeling compulsion to cut her hair off. Upon presentation, she stated, "I feel like a monster with one breast."

M. reported that she started cutting off her hair three years ago. Initially, it was once or twice a month but recently it has become worse to a point where she is cutting her hair almost twice or thrice weekly, and sometimes daily. She states that she feels irritable and anxious whenever she tries to stop and feels guilty and miserable after the act.

M. is a tall, large-boned, pale looking woman who appears her stated age and is always well groomed and neatly dressed. She wears a terry cloth cap, similar to those worn by cancer patients undergoing chemotherapy. She maintains good eye contact throughout the sessions. She brings a great deal of emotional energy to the sessions and shows a wide range of affects. She does not appear depressed nor is she suicidal, but there is a seriousness to her mood. She shows no evidence of thought or perceptual disorder. She appears intelligent and to have adequate judgment. M. has never been late for her appointments and has never missed one without prior notification. She pays promptly at the start of each session.

M. reports having low mood, anhedonia, and fatigue along with her hair cutting for the past three years. She could not relate any specific thoughts that seem to drive her behavior of chronic hair cutting other than she feels like a "monster" with just one breast. She developed these symptoms after being diagnosed with cancer of the breast, at which time she had unilateral mastectomy without reconstructive surgery. Reconstruction was not performed because she did not return for follow-up care and she did not have the resources to pay for reconstruction, which was not covered by any insurance carrier she had at the time. She associates her hair-cutting behavior with her mastectomy.

BACKGROUND INFORMATION

M. initially reported a good marriage but later in the course of therapy she confessed that she has not been intimate with her husband since her surgery, despite him making sexual advances. They have separate bedrooms, and she states that her reason for not being physically intimate is her body image. She shows her dissatisfaction over her body, including her height and weight, by referring to herself as "big and huge."

KEY POINT: Relieve Anxiety and Depression

Studies show that many breast cancer survivors suffer silently and rarely request psychological assistance. Attempts at support from friends and family emphasize the positive and hopeful aspects of the situation. Ironically, this prevents the patient from acknowledging and expressing her negative feelings. These women can benefit from psychotherapy, where they are able to express and process their fears and concerns without alienating or stressing the support system of their family and friends.

The most frequent psychological reaction to all cancers, to the point of being labeled "normal" in the literature, is depres-

M. [a breast cancer survivor] reports having low mood, anhedonia, and fatigue along with her hair cutting for the past three years and says that **she feels like a monster with just one breast**, which is the reason she cuts her hair [almost daily].

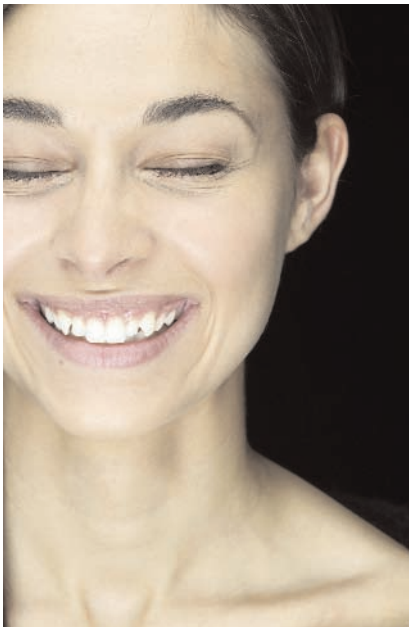
sion, which is often coupled with anxiety or anger. Several studies have linked depression to mastectomy as a psychological consequence.[4–6] Referral to a psychiatrist who can provide antidepressants and anxiolytics together with psychotherapy can ameliorate symptoms and help the patient adopt effective coping strategies.

In this case, M. was started on sertraline (Zoloft®, Pfizer Inc.) 25mg, which was gradually increased to 100mg over the course of two weeks. She tolerated the medication well and reported an improvement of her depression and symptoms of anxiety.

KEY POINT: Awareness of Psychopathology and Symptoms in Order to Assist the Patient in Developing Coping Strategies

Breast cancer and surgery elicit many fears and concerns. Fear of cancer itself, of its recurrence, and of death are commonly reported.[7,8] These fears can leave patients feeling hopeless, and they may have no avenue to ventilate or process these feelings. Patients can suffer for years worrying about these concerns. Unfortunately in M.'s case, she may have suffered needlessly for over five years, because she did not give herself the opportunity to discover that she likely was now cancer-free and that breast reconstruction could be made available to her.

M.'s refusal to follow up with her surgeon for any investigations, such as mammograms, were due to her fear of recurrence and feeling that she could not cope with hearing such a dismal diagnosis. The withdrawal from her husband was an attempt on her part to prepare him for her death. Although M. never required chemotherapy, she adopted the clothing of a cancer patient who had had chemotherapy by always shaving her hair and wearing a terry cloth cap.



M. has decided that since she is not likely going to die of breast cancer after all and has had so much exposure to cancer patients **she would like to be a volunteer at a local hospital to help other people survive the diagnosis of cancer** and get on with their lives.

KEY POINT: Awareness of Body Image and Sexual Dysfunction Related to Mastectomy or Cancer Treatment

Psychological, social, and sexual disturbances are common outcomes after a diagnosis of breast cancer and treatment. Specifically, sexual problems are frequently reported by mastectomy patients and their husbands.[9–12]

During the course of M.'s therapy she was able to talk about her feelings of having mastectomy and living as a cancer survivor. The common/repetitive themes were her body image, her sexual aversion, and fear of recurrence. Loss of libido is a common problem reported by up to one third of women who had enjoyed an active sex life prior to breast cancer.[1,3] This loss of libido results either from depression or body image problems and is sometimes exacerbated by medications taken post-mastectomy to prevent recurrence.

In cases of depression, treatment with antidepressants and supportive psychotherapy has been found to be helpful.

When there is a disturbance of body image, behavioral techniques involving both the patient and her partner (e.g., cojoint sexual therapy) and cognitive behavioral therapy have resulted in improvement.

THE COURSE OF TREATMENT OF M.

M. was seen weekly for one and one-half years in psychotherapy. She was also treated with antidepressant medications. The first task of therapy was to help the patient find the strength to determine the status of her cancer and whether or not she needed further treatment.

She made an appointment with her original surgeon, who recommended a mammogram. Mammography was done and showed no recurrence.

On a follow-up appointment with her surgeon, breast reconstruction was discussed. The patient was guided through social services so that she could receive assistance paying for reconstruction, and this was scheduled.

She discussed her need to cut her hair. Hair cutting has decreased to the point of occurring once or twice in a month, rather than several times a week.

The therapist met with the patient's husband, and the couple was referred for couples counseling. They still have separate bedrooms, and the patient is still uncomfortable about resuming their sexual relationship. However, she is much more open to other expressions of physical affection from her husband than she was at the beginning of therapy.

M. has decided that since she is not likely going to die of the breast cancer after all and has had so much exposure to cancer patients, she would like to be a volunteer at a local hospital to help other people survive their diagnoses of cancer and get on with their lives.

REFERENCES

1. Fallowfield LJ, Hall A. Psychosocial and sexual impact of diagnosis and treatment of breast cancer. *Br Med Bull* 1991;47:2;388–99.
2. Brad M, Sutherland AM, Psychological impact of cancer and its treatment. IV. Adaptation to radical mastectomy. *Cancer* 1955;8:656–72.
3. Maguire GP, Lee EG, Bevington DJ, et al. Psychiatric problems in the first year after mastectomy. *Br Med J* 1978;279:963–5.
4. Morris T, Greer S, White P. Psychological and social adjustment to mastectomy: A 2-year follow-up study. *Cancer* 1977;40:2381–7.
5. Mcguire P. Psychiatric problems after mastectomy. In: Brand PC, Van Keep PA (eds). *Breast Cancer: Psychosocial Aspects of Early Detection and Treatment.* Baltimore, MD: University Park Press, 1978.
6. Ray C. Adjustment to mastectomy: The psychosocial impact of disfigurement. In: Brand PC, Van Keep PA (eds). *Breast Cancer Psychosocial Aspects of Early Detection and Treatment.* Baltimore, MD: University Park Press, 1978.
7. Polivy J. Psychological effects of mastectomy on a women's feminine self concept. *J Nerv Mental Dis* 1977;164:77–87,
8. Schain W. Psychosocial issues in counseling mastectomy patients. *Counsel Psychol* 1976;6:45–9.
9. Bransfield DD. Breast cancer and sexual functioning:A review of the literature and implications for future research. *Int J Psych Med* 1982-83;12:197–211.
10. Jamison KR, Wellisch D, Pasnau R. Psychosocial aspects of mastectomy: I. The woman's perspective. *Am J Psych* 1978;135:432–6.
11. Morris T. Psychological adjustment of mastectomy. *Cancer Treat Rev* 19794:41–61.
12. Wellisch D, Jamison KR, Pasnau R. Psychosocial aspects of mastectomy: The man's perspective. *Am J Psych* 1978;135:543–6.